Regionalization of Health Care Services within the Department of Defense

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The study presents a review of the regionalization efforts within the private sector and the Department of Defense (DOD) as well as discusses possible improvements to this regionalization system. The research elaborates on possible steps that DOD may take to implement regionalization on a tri-service level realizing that in an austere financial environment, centralized supervision and jurisdiction may reduce duplicated services. Several alternatives were discussed to strengthen the DOD Regionalization Program by cooperative assistance among military facilities and physician referrals.

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Introduction

Military health care is considered to be expensive and costs are rising. In Fiscal Year 1980, 4.5 billion dollars were requested to provide health care to authorized beneficiaries[1]. The costs and benefits of the existing military health care delivery system are being closely scrutinized and questioned by many parties. The resulting cry is that "something must be done" to contain costs, use resources efficiently, and yet provide both the quality and quantity of care needed. One "something" that is proposed is regionalization of the military health care system.

Regionalization is a concept that may be approached from two points of view. Some authors look at regionalization as the rational geographic distribution of facilities and programs as well as the referral patterns between institutions and practitioners[2]. Cooperation and coordination between institutions, providers, and programs on an area basis are considered to be the essence of regionalization by other authors[3]. From either point of view the goal of regionalization is the establishment of a rational and effective health care delivery system which functions in an economical manner. This is primarily accomplished by eliminating duplication and promoting the efficient use of resources.

The purpose of this analysis is to first present a review of regionalization efforts that have occurred within both the private sector and the Department of Defense (DoD). Second, some opinions will be presented on the subject of regionalization in the private sector, within DoD, and between DoD and the other sectors. Third, based on some of the activities in the private sector, possible alternatives will be presented on how regionalization within DoD could be improved. Finally, conclusions about regionalization efforts and the implications for the future will be drawn.

Discussion

Regionalization in Review

The past decade has seen the concept of regionalization rise to national prominence. The National Health Planning and Resource Development Act, Public Law (P.L.) 93-641, made the rational delivery of health care a national goal and regionalized arrangements became yardsticks by which progress towards cooperation and joint planning could be measured. However, this was not a "new" concept. Hill-Burton legislation, Comprehensive Health Planning, and Regional Medical Programs had all attempted to promote the goals of regionalization.

The concept of regionalization that was described under P.L. 93-641 calls for supervision and jurisdiction over the planning process to be centralized at the regional level. Regional planners were to be dedicated to common goals and interests of a designated area, balancing needs and resources throughout it. Ideally, these planners and decision makers were placed in such a manner so that they could perceive local needs, yet far enough removed to remain independent of individualistic local pressures.

The Federal sector was not specifically addressed in this legislation but it was caught up in the surge of interest and planning efforts of the period. From 1972 to 1979 the Tri-Service Medical Coordinating Committee, the Armed Forces Regional Health Services System, the Department of Defense Health Health Council, and the Federal Health Resources and Sharing Committee appeared within DoD. All were efforts to increase sharing, coordination, and cooperation. During the same period various panels, hearings, and studies addressed the same subjects. Other plans, regulations, and directives were formulated and implemented in an attempt to encourage coordination between the Federal sector and the Health System Agencies (HSA's) established by P.L.93-641.

Some efforts in the private sector, such as End-Stage Renal Dialysis and Perinatal Care Programs, reportedly achieved limited success in their efforts to establish rational systems that were linked by formal and informal sharing, coordination, and cooperation. Shared services, cross utilization of personnel, and other limited regionalized arrangements for certain sophisticated and expensive technologies have also been reported in the Federal sector[4].

Regardless of this activity, little real progress has been reported toward achieving regionalization in either the Federal or the non-Federal sector. Some of the regionalized systems that do exist may not have been established if the government had not exerted leverage on the planning process through their use of economic persuasion. In general, regionalization has not been successful on either the institutional or macro level[5]. This lack of progress did not go unnoticed. Further legislation, P.L. 96-79, was passed in 1979 in an effort to get those in the non-Federal sector to increase their efforts at achieving regionalization, coordination, and cooperation. In 1980, Congress also accused the Federal sector of being remiss in their efforts to share, coordinate, and cooperate[6].

While regionalization was being externally mandated by government, a voluntary effort to reduce duplication and waste was appearing in the private sector. This effort was in the form of multihospital systems and shared services organizations. These arrangements were demonstrating an improved capacity for the efficient use of scarce medical resources and they appeared to be establishing rational, economic systems on a limited basis. These organizations were not only sharing, coordinating, and cooperating within their structures, they were doing it between organizations and systems.

Opinions on Regionalization

In the Private Sector

Limited area ventures in sharing, cooperation, coordination and actions to rationally structure delivery systems were attempted because they were methods of assuring that the goals and objectives of the institutions could be achieved under ever increasing economic, political, and social pressures. In simpler terms, survival was the primary driving force[7]. Survival was achieved through economic efficiencies, gains in political and economic power, and the ability to use this power in numerous varied arenas. It was also secured through efforts to comply with the onslaught of government rules and regulations produced under P.L. 93-641. Institutions and providers could show that they were attempting to comply with both the spirit and the intent of the law. Social benefits were also being produced. Programs were improved and health care delivery systems were improved in both a quantitative and qualitative manner.

Other motivations led institutions and providers to remain in the systems once they were formed. Centralization of services, economies of scale, and sharing of certain services were providing economic benefits to participants. Forums for the mutual exchange of ideas and experiences were also established in some systems. Managers were being intellectually stimulated and satisfied. Status was also given to those who were successful in attempts to implement regionalized arrangements. They were viewed in some sectors as the most efficient and effective managers of the period. Providers and institutions appeared willing to sacrifice various degrees of autonomy to gain the advantages of such systems and groups.

Sharing, cooperating, coordinating, and attempts to structure rational delivery systems were not the sole key to the apparent success achieved in the

private sector. These were only a few of the efforts undertaken to conduct operations in a "business like" manner. Concepts such as vulnerability analysis, life cycle costing, system diversification, and marketing became commonplace in hospitals. Perhaps of greatest importance was the initiation of aggressive programs in productivity management. The common opinion was that "in the long run, effective cost containment depends on increased productivity"[8]. Strategies that utilized all these tools were developed and implemented to insure not only survival, but growth.

These systems were not without problems. It was soon realized that greater sophistication and specialization were needed to manage labor, capital, and resources in these systems. Complex organizations were being formed that were placing new demands on managers to deal with employee apprehension, legal and economic challenges, and other complexities of institutional decision making created by these arrangements.

In the Department of Defense

Numerous forces and factors exist that have impacted upon the implementation of this concept within DoD. The rationality of the geographic distribution of DoD facilities and programs is a matter of opinion. The location of most of these facilities is a function of history. They were established near troop concentrations and/or major transportation centers. In addition, the requirements to train personnel in preparation for war by providing them with the widest range of exposure to various diseases and conditions have impacted on site determination. Other forces that are beyond the control of DoD have impacted on the current arrangement of facilities. Both the beneficiaries of care and those who make their living, either directly or indirectly, from these facilities have strong interests in the location of such facilities. Their interests readily convert to political influence over such decisions.

The debate over the rationality of arrangements of facilities and programs may be a moot point. Given the sunk costs in the existing system and the high construction and start up costs of some programs our current arrangement may be the most rational and economic. Some complain that waiting periods are too long, retired beneficiaries have better access to specialty care, and that some must travel to other locations to receive certain types of care. However, these are commonplace to all systems that have implemented regionalized arrangements of care. There will always be trade-offs in such a system.

DoD has established the Armed Forces Regional Health Services System to act as the "principle means of coordinating the organization and management of health care delivery on an integrated tri-service basis"[9]. In addition, centralization of policy formulation and centralization of control over the use of capital are well established within DoD. Both are considered to be strategic requirements for coordination and cooperation[10]. Goals and objectives to achieve regionalization have also been established and a Tri-Service Regional Review Committee exists in each region to bring regionalized planning to the local level. However, there appears to be a number of significant problems in relation to sharing, coordination, and cooperation. These problems have created significant gaps between policy directives and their application to various programs. Some of these problems are:

(1) Parochialism between services and corps. Interservice rivalries exist as does the "bigger is best" school of thought.

(2) A lack of incentive to share, coordinate and cooperate. Forced coordination has been the consistent recommendation of a generation of studies on the military health care system[11]. However, forcing these concepts into a system without providing incentives to surrender autonomy has been a

consistent problem in achieving regionalization. Some disincentives also exist. Since the military system ties funding and manpower to workload why should any organization work towards possibly decreasing their workload?

(3) The literature demonstrates that numerous councils, committees, and directives have been formulated in the Federal sector to meet the mandates for regionalization. These multiple forces have attempted action to achieve cost containment, identification and elimination of duplication, and efficiency in the use of resources. However, they were single, unintegrated actions that have led to confusion as well as possible barriers to sharing and cooperation.

(4) That the DoD health care delivery system is deeply embedded in a large, inflexible bureaucracy that creates further mechanical and organizational barriers to efficient, effective, and timely implementation of regionalization.

(5) Few formal or informal mechanisms on the regional level for the free exchange of ideas between various tri-service managers with common areas of interest (e.g. logistics, patient administration, clinical support).

(6)That DoD has not taken advantage of every opportunity to promote a total management approach to achieving the desired end results of cost containment, coordination, and efficiency. An aggressive productivity management program at both the centralized and institutional level has not been implemented.

(7) That the impact of the problems listed may significantly foster a lack of philosophical commitment by managers within DoD to this concept. The private sector demonstrates that efforts at regionalization are more successful when there is a total management philosophy present that consistently approaches the subject in a unified, positive manner at all levels of operation.

The problems listed are considered to be major problems that have blocked the implementation of regionalization within DoD. Others exist, but these are considered to be of greatest importance when looking at the

reasons for success of multihospital systems and shared services arrangements.

Between DoD and the Other Sectors

The degree that the military medical system can be regionally integrated with the other sectors depends on the compatability of goals and objectives between these sectors. The Federal sector has been directed to interact with the local HSAs and they, in turn, are to take the military health care capabilities and services into account when doing regional planning[12]. However, the primary mission of the military health care system is not congruent with the goals and objectives of the other sectors which leads many to retain the belief that DoD must remain a closed system constantly preparing to meet its mobilization mission. The military services exist to go to war. Any arrangements that would interfere with this mission must be avoided. The benefits of such arrangements must be closely weighed against the possible costs. It would appear that the government has not intended the Federal sector to be integrated into the other sectors since they were not addressed in legislative action promoting regionalization.

Possible Alternatives For Improving Regionalization in DoD

Any type of allocation process for scarce resources has significant problems. Among these are: The disproportionate influence over the allocation process by those already possessing resources; personal interests; disproportionate attention to the powerful; inadequate funding and staffing to do proper planning and priority setting; and preoccupation with political rather that planning tasks in allocating resources[13]. These problems, plus those specifically addresssed in this discussion, may reduce regionalization to a conceptual philosophy instead of a realistic plan of action. However, before this decision becomes final there are some alternatives that have been

successfull in the private sector that have not yet been fully explored in the Federal sector.

The Tri-Service Regional Review Committees were established to review and assess the health services capability and operations in their regions. However, because of the problems that exist, these committees have not consistently functioned in the role of regional planners. These bodies have not had clearly defined roles and responsibilities nor have they been given the assets to accomplish planning and evaluation functions within their regions. A viable alternative for strengthening regionalization within DoD would be to strengthen the role of these committees. Their role should be proactive as well as reactive. They should: identify and take actions to eliminate inefficiencies in resource allocation within their regions; study the distribution of services and resources making recommendations for improving delivery systems and referral patterns; promote sharing, coordination, and cooperation within the military delivery system; and coordinate with others providing health care within their region. Regional management must have a strong role in identifying health care issues and needs within their region and the responsibility for responding to them or referring them into the appropriate channels where they can be resolved.

This alternative does not imply the creation of a new form of organization or management group within the regions. Adding new levels of bureaucracy will not improve coc ·ration and coordination. The structure of this committee must still consist of the military managers in the region meeting at periodic intervals. However, the number and location of regions must be further studied. The current regions are too large to attempt a proactive as well as reactive approach to regionalization. The civilian experience with the HSA's has demonstrated the need for smaller regions where this proactive role can become a reality.

One area within this alternative should receive further serious consideration. If we are to share, coordinate, and cooperate at the Federal level, then all Federal health care managers within the given region should be invited to attend the meetings. Among others, the Veterans Administration and the Public Health Service should be included so that free exchanges of ideas and problems can occur. The military function of the committee spelled out by regulation would remain with the DoD managers on the committee.

An alternative that could improve cooperation, coordination, and sharing without sacrificing autonomy would be the formation of limited interest tri-service councils on a regional basis. This has been done in the private sector multihospital systems and has produced benefits for the systems[14]. Military managers from within the entire region who have common areas of interest and responsibility, such as logisticians and comptrollers, would meet on an informal basis for a free exchange of ideas, concepts, complaints, and problems. The councils would submit their findings and recommendations to the Tri-Service Region Review Committee for further study or action. The councils would act as a group of informal consultants to the Committee with certain problems identified by the Committee sent to the councils for study and analysis with findings, with recommendations being returned to the Committee. Again, attendance at these council meetings would not be limited to DoD. Health care managers from the Veterans Administration and other Federal health care agencies who share the common areas of interest would also attend such meetings. Such interactions would increase information flow, cooperation, coordination, and mutual trust; all of which are necessary elements of regionalization.

The question of incentives to promote regionalization concepts present a difficult problem. Forced sharing and cooperation imparts a negative incentive

that managers and institutions must comply or else. However, cooperation cannot be forced, it must arise from within the participants. An alternative that has not been used extensively is the use of efficiency reports and awards to promote cooperation. Those who strive to cooperate within their organization and within the region could have that fact entered in their efficiency reports. Promotion boards and school selection boards could be directed to use this as an indicator of managerial efficiency and effectiveness. Awards could be given to those who strive to cooperate, coordinate, and share in their respective systems.

Finally, regionalization alone will not produce all the desired outcomes of cost containment, rationality of system arrangements, and increased efficiency. Other programs, such as productivity management, must be developed and implemented within the system to provide a comprehensive approach to today's real problems as well as tomorrow's potential problems. Incentives should be developed to promote both regionalization and productivity. Single efforts and concepts are not satisfactory to meet the complexities that are present in the military health care sector. Regionaliz is not a goal; cost containment and increased efficiency are goals. The accomplishment of these ends requires the use of all available methods and concepts, including regionalization.

Conclusions

The rational geographic distribution of health care facilities and programs as well as sharing, cooperation, and coordination between institutions, providers, and programs can be externally mandated, internally mandated, internally developed, or some combination of the three. The private sector has seen all three mechanisms come into play. P.L. 96-641 and other legislation

externally mandated regionalization. The central decision making bodies for the organizations and systems internally mandated such programs. At the same time, internal driving forces such as those described in this article were present which fostered the development and survival of such programs.

In DoD, external mandates to promote regionalization, sharing, coordination, and cooperations are also seen. The centralized decision makers within DoD are also internally mandating the establishment of programs in these areas. However, internal driving forces seen in the private sector are not apparent within DoD. Because of the type of problems identified in this article these internal forces have been consistently blunted. History has demonstrated that the arrangement of facilities and programs can be forced but real success in achieving sharing, cooperation, and coordination stems from commonality of commitment and internal incentives to become more productive. As one author states "it takes faith and commitment to engage in cooperative ventures"[15].

Regionalization is a concept that is here to stay. Although DoD has managed to escape some of the efforts to force this concept into reality it would appear that it will not continue to do so much longer. To meet the future impacts of external mandates for increased sharing, cooperation, and coordination DoD must improve its own internal directives and policies and take actions to promote the internal forces that are needed to bring this concept to operational reality.

This article has offered several alternatives for strengthening internal policies and driving forces needed for such programs. These actions are but a starting point. History has shown that successful programs started on small points and grew. As managers interact, new ideas will arise that will form a base for future increases in sharing, cooperation, and coordination. Hopefully, as DoD achieves these goals within their own sector then regionalization between DoD and the other sectors of the health care delivery system can be approached.

Footnotes

[1]Vernon McKenzie, "Federal Medical Chiefs on Progress and Plans," Military Medicine 143 (September 1978): 605.

[2]Milton I. Roemer, "Regionalized Health Systems in Five Nations," Hospitals 53 (16 December 1979): 72.

Anne R. Somers and Herman M. Somers, Health and Health Care (Germantown: Aspen Systems Corp., 1977): 252.

[3]R. Coniff "Blood Bank Regionalization: Boon or Bane?" MLO 11 (November 1979): 45.

Gerald Katz, "Regionalization Among Children's Hospitals," Hospital and Health Services Administration 25 (Fall 1980): 57.

Health Systems Plan 1979-1981. (Salinas, California: The Midcoast Health Systems Agency, 1979): G-16.

[4]LTG Charles C. Pixley, in "Federal Medical Chiefs on Progress and Plans," Military Medicine 145 (September 1980): 604.

[5]Katz, p. 71.

[6]The Honorable Charles Percy. Federal Interagency Medical Resources Sharing and Coordination Act of 1980. S. 2613. Washington, D.C.: The Senate of the United States, 3 January 1980. p. 2.

[7]Robert Cunningham. "Systems: Good News and Bad News" Hospitals 54 (1 August 1980): 62.

[8]Joan Marron-Cost, "Productivity: Key to Cost Containment," Hospitals 54 (16 September 1980): 77.

[9]U. S. Department of the Army. Army Medical Department Facilities/ Activities. AR 40-4. Washington, D. C. The Adjutant General Center, January 1, 1980. p. 9.

[10]Bernard Locker and Douglas Rosenberg, "Environmental Change Faces Hospital CEO's, Hospitals 54 (1 January 1980): 75.

[11]Richard Ginn. "Of Purple Suits and Other Things: An Army Officer Looks at Unification of the Department of Defense Medical Services" Military Medicine 143 (January 1978): 24.

[12]Federal Register 43 (January 20, 1978): 3059

[13]Henry Sedler, "Planning and Politics in the Allocation of Health Resources", American Journal of Public Health 20 (Winter 1975): 8.

[14]Scott S. Parker and Kevin S. Wordell. "Multihospital Systems Form a Cooperative for Sharing Services" Hospitals 54 (16 June 1980): 80.

[15]Theodore Litmon and George Johnson, "Sharing Services: The Dynamics of Institutional and Administrative Behavior." Hospital and Health Services Administration 25 (Fall 1980): 18.

SELECTED BIBLIOGRAPHY

Public Document

U. S. Department of the Army. Army Medical Department Facilities/Activities, AR 40-4, Washington, D. C.: The Adjutant General Center, January 1, 1980.

U. S. Department of the Army, Health Services Command. Annual Historical Review (RCS-CSHI5-6R3), San Antonio, Texas, 1 March 1978.

Health Systems Plan 1979-1984. Salinas, California: The Midcoast Health Systems Agency, 1979.

Proposed Health Systems Plan for the People of New York City. New York: The Health Systems Agency of New York: 1977.

The Honorable Charles Percy, Federal Interagency Medical Resources Sharing and Coordination Act of 1980. S. 2613. The Senate of the United States, Washington, D. C. 3 January 1980.

Books

Cullis, John G. and West, Peter A. The Economies of Health. New York: New York University Press, 1979.

Ginzberg, Eli. Regionalization and Health Policy. Washington, D. C.: Government Printing Office, 1977.

Haltzman, Joseph M. Regionalization Planning and Coordinating Structures in Health Care. Hartford, Conn: University of Connecticut. 1975.

Shonich, William, Elements of Planning for Area-Wide Personal Health Services, St. Louis: C. V. Mosby Co., 1976.

Somers, Anne R. and Somers, Herman M. Health and Health Care. Germantown: Aspen Systems Corp. 1977.

Periodicals

Coniff, R. "Blood Bank Regionalization: Boon or Bane." MLO" (November 1979): 45.

Coyne, Joseph. "Nonprofit Hospital Groups Make a Move on Investor Owned Systems" Modern Healthcare 9 (November 1980): 82-88.

Cunningham, Robert M. "Systems: Good News and Bad News." Hospitals 54 (1 August 1980): 62-65.

D. Paolo, Vince. "Chains Expecting Hefty Earnings Gains in 1980". Modern Healthcare 10 (January 1980): 75.

Friedman, Emily. "The Long Road to Regional Blood Programs." Hospitals 54 (1 October 1980): 53-57.

Ginn, Richard V. "Of Purple Suits and Other Things: An Army Officer Looks at Unification of the Department of Defense Medical Services." Military Medicine 143 (January 1978): 15-24.

Harrison, J. A. "Military Medicine in the United Kingdom: Similarities and Differences with Respect to the United States and Other NATO Allies." Military Medicine 145 (June 1980): 387-393.

Johnson, Donald E. "Mackey: For Profit Systems will Thrive". Modern Healthcare 9 (August 1979): 22-23.

Jones, Wanda J. Multihospital System's Goals and Structures Change as They Mature." Modern Healthcare (April 1980): 94-98.

Katz, Gerald. "Regionalization Among Children's Hospitals" Hospital and Health Services Administration 25 (Fall 1980): 56-72.

Littmon, Theodore and Johnson, George. Sharing Services: The Dynamics of Institutional and Administrative Behavior" Hospital and Health Services Administration 25 (Fall 1980): 7-22.

Lachner, Bernard J. and Rosenberg, Douglas O. "Environmental Changes Faces Hospital CEO". Hospitals 54 (1 January 1980): 75-77.

Monken, Douglas C. and Glueck, William F. "Strategic Planning." Hospital and Health Servides Administration (Spring 1977): 6-22.

Marron-Cost, Joan. "Productivity: Key to Cost Containment." Hospitals 54 (16 September 1980): 77-79.

McKenzie, Vernon in"Federal Medical Chiefs on Progress and Plans," Military Medicine 144 (September 1978): 605.

Parker, Scott S. and Wordell, Kevin, S. "Multihospital Systems Form a Cooperative for Sharing Services." Hospitals 54 (16 June 1980): 79-84.

Pixley, Charles C. in "Federal Medical Chiefs on Progress and Plans." Military Medicine 145 (September 1980): 604.

_____. "Report Recommends New Policy on Size of Military Hospitals." Hospital Week 16 (19 December 1980): 3.

Roemer, Milton I. "Regionalized Health Systems in Five Nations." Hospitals 53 (16 December 1979): 72-82.

Rosenfield, Leonard S. and Rosenfeld, Irene. "National Health Planning in the United States." International Journal of Health Services 1975, 441-453.

_____. "Summary of the 1979 Health Planning Amendments." Public Health Reports 95 (March-April 1980): 183-188.

Sedler, Henry. "Planning and Politics in the Allocation of Health Resources." American Journal of Public Health 20 (Winter 1975): 8-16.

_____. "The Future of the Veterans Administration Hospital System: Two Points of View." The New England Journal of Medicine 298 (16 March 1978): 623-628.

_____. Federal Register 43 (26 January 1978).

_____. Federal Register 41 (13 January 1976).